STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Assisted Living Facility in Johnson, Kansas on 8/08/16, 8/09/16, 8/10/16, 8/11/16, 8/15/16, and 8/16/16. Revised 2567 sent to facility 8/29/16	S 000		
S 225 SS=E	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This information shall include the refund policy of the adult care home.(3) At the time of admission, the	S 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 225	Continued From page 1 administrator or operator, or the designee, shall execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents. (5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(a)(1)(C)(2)(3) The census equalled 11 the sample included three Residents. Based on interview and record review, for three of three sampled, (#189, #187, and #185), the Operator failed to inform the prospective Resident or their legal representative, in writing, of the rates and charges for the facility services, with Resident's obligation toward payment, and, failed to execute a written agreement at the time of admission that described in detail the services and goods the Resident to receive and specified obligations of the Resident to the facility. Findings included: - Review of record revealed #187 admitted to facility 12/31/15 with diagnoses of Malnutrition and Hypertension. The current 5/06/16 functional capacity screen	S 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 225	Continued From page 2 (FCS) assessed #187: in need of physical assistance (2) for Bathing then crossed out with (1) for supervision added; independent with Dressing, Toileting, Transfers, Mobility; in need of physical assistance for Eating; unable to perform (3) medication and treatment management; usually continent. The 5/05/16 negotiated service agreement (NSA) documented facility staff to provide assistance with these identified needs. By review, this medical record lacked any portions or forms to indicate an admission agreement presented or developed. - Review of record revealed #185 admitted to facility 3/18/16 with diagnoses of Mitral regurgitation, Transient Ischemic attack, Right heart failure, Atrial fibrillation, and Hypothyroidism. The current 3/18/16 FCS assessed #185: independent (0) with bathing, dressing, toileting, transfers, mobility, eating, medication and treatment management. The 3/18/16 NSA documented facility staff to provide assistance with any general needs. The record contained a copy of Resident Rights, an Advanced Directive acknowledgement form, a Mission Statement, and a Rental charges form, all signed 3/31/16; and a "Criteria for Admission" form signed on 01/03/16. This combination of forms did not represent a written admission agreement provided and explained verbally at the time of admission on 3/18/16. - Review of record revealed #189 admitted to	S 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 225	Continued From page 3	S 225		

facility 3/10/16 with diagnoses of Hypertension, Depression, Cognitive decline, Glaucoma, Macular degeneration, Hearing impairment, Arthritis, and Gout.

The current 3/10/16 FCS assessed #189 in need of physical assistance (2) with bathing and dressing; in need of supervision (1) with toileting, transfers, mobility; independent (0) with eating; unable to perform (3) medication and treatment management; incontinent of bladder; with short term memory and long term memory, memory recall and decision making impairments; impaired communication; with falls/steadiness; with vision and hearing impairments.

The 3/10/16 NSA documented facility staff to provide assistance with these identified needs.

By review, the medical record contained a Mission Statement, a Responsible Party Authorization form, a Photo permission form, an Advanced Directive Acknowledgement form, and a copy of the Fire Policy.

The medical records for #187, #185, and #189 each lacked an admission agreement. The medical records contained an assortment of admit policies, listings of admission criteria, and listings of do's and don't for facility living.

By interview on 8/09/16 at 2:50pm, Operator/CNA (certified nurse aide) #I stated we really don't have an admission agreement... I thought the NSA took care of that... may have had one in the past but since I've been here we have used these various forms at time of admission. Operator/CNA #I confirmed these forms do not cover all required areas... for example the rate is covered in the NSA not in the admission papers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 225	Continued From page 4 The Operator failed to notify Residents in writing or obtain a written agreement detailing rates and charges and payment obligations of #187, #185, and #189, on or before their admission to the facility.	S 225		
S 230 SS=E	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(c) The census equalled 11 the sample included three Residents. Based on interview and review of record, for two of three sampled (#187 and	S 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 230	Continued From page 5 #185), the Operator: Failed to inform the Resident or the Resident's legal representative, in writing, of the state statutes related to advance medical directives; and Failed to ensure the implementation of facility policies and procedures that specified if a Resident has an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive. in the medical record. Findings included: - Review of record revealed #185 admitted to facility 3/18/16 with diagnoses of Mitral regurgitation, Transient Ischemic attack, Right heart failure, Atrial fibrillation, and Hypothyroidism. The record contained an Advanced Directive acknowledgement form. This form specified #185 had a Living Will and a Durable Power of Attorney for Health Care. The medical record lacked copies of these documents. The medical record failed to indicate what written information provided to Residents in regard to Advanced Directive state statutes. By interview on 8/09/16 at 10:36am, Operator/CNA (certified nurse aide) #I confirmed the medical record did not contain copies of the designated Advanced Directives... stated we don't do that (provide written advanced directive information regarding state statutes)... we don't have anything we give in writing... our nurse just talks to them at admit time... I don't know if we have a policy for that. The Operator failed to inform #185 in writing, of	S 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 230	Continued From page 6 the state statutes related to advance medical directives; and failed to ensure the implementation of facility policies and procedures that specified if a Resident has an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive in the medical record. - Review of record revealed #187 admitted to facility 12/31/15 with diagnoses of Malnutrition and Hypertension. The medical record lacked evidence of written advanced directive information regarding state statutes provided to #187 at time of admission. The medical record contained an incomplete "Durable Power of Attorney for Health Care" form that lacked any signature by the Resident or the Resident's representative, and the form lacked notarization as required. The medical record also contained an incomplete 12/30/15 "DNR" (do not resuscitate) form that lacked a witness signature. The Operator failed to inform #187 in writing, of the state statutes related to advance medical directives; and failed to ensure the implementation of facility policies and procedures that specified if a Resident has an advanced directive currently in effect, the facility shall maintain a copy of Resident's advanced directive in the medical record.	S 230		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3082	Continued From page 7 resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility census equalled 11 the sample included three Residents. Based on review of records and interviews, for two of six sampled (#187 and #185) the Operator failed to ensure designated facility staff completed a functional capacity screen (FCS) that accurately reflected the Residents's functional capacity. Findings included: - Review of record revealed #185 admitted to facility 3/18/16 with diagnoses of Mitral regurgitation, Transient Ischemic attack, Right heart failure, Atrial fibrillation, and Hypothyroidism. The current 3/18/16 FCS assessed #185with a cognition score of 25: Short Term Memory "10"; Long Term Memory "3"; Memory/Recall "3"; Decision-Making "9". The FCS manual identified one possible point for each of these four areas, allowing for a maximum total of "4." The codes of this FCS did not accurately match the definitions of the FCS manual used to complete this assessment tool. On 8/09/16 at 6:00pm, RN (registered nurse) #H confirmed he/she thought the FCS form referred to a required MMSE (mini mental state examination)... did not realize the form referred a	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3082	Continued From page 8 "1" or "0" scoring system detailed in the FCS manual. The Operator failed to ensure designated facility staff completed an FCS that accurately reflected #185's functional capacity. - Review of record revealed #187 admitted to facility 12/31/15 with diagnoses of Malnutrition and Hypertension. The current 5/06/16 functional capacity screen (FCS) cognition section coded as: Short Term Memory - coding box left blank, with note written to the side "some issues." Long Term Memory - coding box left blank, with note written to the side "mostly accurate" Memory/Recall - coding box with "0" Decision-Making - coding box with "0" Total Score Box - empty The previous FCS dated 12/31/15 cognition section coded as: Cognitive of the FCS coded the following: Short Term Memory - coding box left blank, with note written to the side "yes some" Long Term Memory - coding box left blank, with note written to the side "mostly" Memory/Recall - coding box with "0" Decision-Making - coding box with "0" Total Score Box - empty The FCS manual identified one possible point for each of these four areas, allowing for a maximum total of "4." The codes of this FCS did not accurately match the definitions of the FCS manual used to complete this assessment tool.	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3082	Continued From page 9 On 8/09/16 at 6:00pm, Registered Nurse #H confirmed the FCS not accurate. The Operator failed to ensure designated facility staff completed an FCS that accurately reflected #187's functional capacity.	S3082		
S3091 SS=D	26-41-202 (e) NSA Nurse Participation (e) A licensed nurse shall participate in the development, review, and revision of the negotiated service agreement if the resident's functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(e) The census equalled 11 the sample included three Residents. Based on reviews of records and interviews, for one of three sampled (#189), the Operator failed to ensure a licensed nurse participated in the development of a negotiated service agreement (NSA) that indicated the need for health care services. Findings included: - Review of record revealed #189 admitted to facility 3/10/16 with diagnoses of Hypertension, Depression, Cognitive decline, Glaucoma, Macular degeneration, Hearing impairment, Arthritis, and Gout.	S3091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3091	Continued From page 10 The current 3/10/16 FCS assessed #189 in need of physical assistance (2) with bathing and dressing; in need of supervision (1) with toileting, transfers, mobility; independent (0) with eating; unable to perform (3) medication and treatment management; incontinent of bladder; with short term memory and long term memory, memory recall and decision making impairments; impaired communication; with falls/steadiness; with vision and hearing impairments. The 3/10/16 NSA documented facility staff to provide assistance with these identified needs. The 3/10/16 NSA lacked a nurse signature and lacked any facility representative signature. The NSA signed by the Resident's Durable Power of Attorney and no one else. The prior 9/14/15 FCS assessed #189 in need of physical assistance (2) with transfers and mobility; unable to perform medication and treatment management; with bladder incontinence; Cognitive remained blank with no coding. The 9/14/15 NSA documented facility staff to provide assistance with these identified needs. The 9/14/15 NSA lacked a nurse signature. By interview on 8/09/16 at 5:35pm, Operator/CNA (certified nurse aide) #I confirmed no nurse signature on the NSA's... confirmed no designated signature space for a nurse on the NSA. The Operator failed to ensure a licensed nurse participated in the development of NSA's for #189 that indicated the need for health care services.	S3091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 11	S3165		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility census equalled 11 the sample included three Residents. Based on reviews of records and interview, for one of three sampled (#187), the Operator failed to ensure the negotiated service agreement (NSA) contained a description of the health care services to be provided; and, for two of three sampled (#189 and #187), the Operator failed to ensure the NSA contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan (HSP). Findings included: - Review of record revealed #189 admitted to facility 3/10/16 with diagnoses of Hypertension, Depression, Cognitive decline, Glaucoma, Macular degeneration, Hearing impairment, Arthritis, and Gout. The current 3/10/16 FCS assessed #189 in need of physical assistance (2) with bathing and dressing; in need of supervision (1) with toileting, transfers, mobility; unable to perform (3) medication and treatment management; incontinent of bladder; with short term memory	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 12	S3165		

and long term memory, memory recall and decision making impairments; impaired communication; with falls/steadiness; with vision and hearing impairments.

The 3/10/16 NSA documented facility staff to provide assistance with these identified needs. The 3/10/16 NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of the HSP.

The prior 9/14/15 FCS assessed #189 in need of physical assistance (2) with transfers and mobility; unable to perform medication and treatment management; with bladder incontinence; Cognitive remained blank with no coding.

The 9/14/15 NSA documented facility staff to provide assistance with these identified needs. The 9/14/15 NSA failed to designate the name of the licensed nurse responsible for the implementation and supervision of the HSP.

The Operator failed to ensure the NSA for #189 contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan.

- Review of record revealed #187 admitted to facility 12/31/15 with diagnoses of Malnutrition and Hypertension.

The current 5/06/16 functional capacity screen (FCS) assessed #187: in need of physical assistance (2) for Bathing then crossed out with (1) for supervision added; in need of physical assistance for Eating; unable to perform (3) medication and treatment management; usually continent. The FCS documented "Feeding Tube"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 13 beside meal preparation, and "Tubal" beside management of medications. The 5/05/16 NSA documented facility staff to provide assistance with medication and treatment management, tube feeding, dressing, change, and help shower. TheNSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HSP (health service plan) and lacked a descrition of the health care services associated with the "Feeding Tube, " including: frequency; type and amount of feeding solution; amount of water to be used before and after feeding solution; procedure; preparation; precautions and monitoring." The medical record documented 5/06/16 physician orders for gastric tube feedings: Isosource one can/carton QID (four times daily) and 60ml water after each feeding. By observation on 8/09/16 at 10:40am, LPN (licensed practical nurse) #F administered scheduled medications and tube feeding. LPN #F administered: Water (#F reported "I gave 40ml (milliliters) because I fill the 20ml syringe twice") Medications crushed and mixed with water Iso Source solution 250ml Water (full cup) again reported by #F as "40cc because I fill the 20cc syringe twice". By observation and interview on 8/09/16 at 5:50pm, LPN #F confirmed the syringe being used was total of 60ml instead of 20ml... confirmed #187 received 120cc water each time water used instead of 40cc.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3165	Continued From page 14 By interview on 8/09/16 at 5:35pm, Operator/CNA (certified nurse aide) #I stated " I was not aware of the need to name the Licensed Nurse responsible for health care of Residents on the NSA. " By interview and observation on 8/09/16 at 5:55pm, Operator/CNA #I, LPN #F, and RN (registered nurse) #H all confirmed staff watched a video on tube feedings; #187's family member demonstrated procedure for staff; LPN #E provided multiple printed resources in a clip in nursing office on tube feedings; but all confirmed the NSA and HSP lacked a description of the services #187 to receive in regard to the feeding tube processes. The Operator failed to ensure the NSA for #187 contained a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the health service plan.	S3165		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 15 which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: 26-41-205(d)(1-2) The census equalled 11 the sample included three Residents. The facility identified one Resident with facility managed medications. Based on observation, interview, and review of record, for one of one sampled Resident with medication management (#187), the Operator failed to ensure all medications administered in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Review of record revealed #187 admitted to facility 12/31/15 with diagnoses of Malnutrition and Hypertension. The current 5/06/16 functional capacity screen (FCS) assessed #187 unable to perform (3) medication and treatment management. The 5/05/16 NSA documented facility staff to provide assistance with medication administration and treatment management. By observation on 8/09/16 at 10:40am, LPN (licensed practical nurse) #F administered medications via stomach feeding tube of #187. LPN #F reported giving Omeprazole, Aspirin,	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 16 Metoprolol, and Minocycline. Comparison of the current August 2016 MAR (medication administration record) with signed written medical care provider orders revealed the following discrepancies: The MAR contained an order for "Metoprolol (blood pressure) 25mg (milligrams) once a day, crush and administer via gastric tube. The signed order for this medication stated "Metoprolol ER (extended release) 25mg daily. The MAR lacked the following medications from a 7/01/16 physician signed page of orders: Amiodarone 200mg daily (blood pressure medication) Glycerin suppository as needed (laxative) Hydrocodone/apap (pain medication) liquid 3 teaspoons every 4 hours as needed Milk of Magnesia as needed (laxative) Odansetron (nausea medication) 8mg every 8 hours as needed Prochlorperazine (anti psychotic and anti nausea) 10mg every 6 hours as needed Senna S as needed (laxative) On 8/09/16 at 6:00pm Operator/CNA (certified nurse aide) #I stated unable to figure out why written physician's orders not on the MAR. On 8/09/16 at 6:17pm, LPN (license practical nurse) #F stated some of them would be "PRN" as needed... some may be discontinued... not able to say why the ordered medications didn't make it on MAR... perhaps the family member has recent written orders from the physician that haven't been put in the chart yet... The Operator failed to ensure #187 received all	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3200	Continued From page 17 medications in accordance with a medical care provider's written order and in accordance with professional standards of practice.	S3200		
S3211 SS=D	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The census equalled 11 the sample included three Residents. The Resident roster identified one Resident with facility managed medications. Based on observations, interviews, and review of record, for one of one sampled (#187), the Operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the Resident on each accepted package of over-the-counter medication for Resident administration. Findings included:	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3211	Continued From page 18 - By observation on 8/09/16 at 5:23pm in the medication storage room of facility, observed an over the counter medication without Resident's first and last name on package. The medication cupboard contained a bottle of 81mg (milligrams) Aspirin. This over the counter medication lacked a name. By interview on 8/09/16 at 5:23pm, CMA (Certified Medication Aide) #J and Operator/CNA (certified nurse aide) #I observed the bottle of aspirin and each stated not aware of the need to have nurse or pharmacist place the Resident's name on over the counter medications... confirmed #187 the only Resident at this time with facility managed medications, but not a facility practice when managing prior Resident medications. For #187 the Operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the Resident on each accepted package of over-the-counter medication for Resident administration.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 19 nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility census equalled 11 the sample included three Residents. Based on observations and interviews, for one of one sampled with medication management (#187), and for all Residents with medications managed by facility, the Licensed Nurses and Certified Medication Aides (CMA) failed to ensure that all medications and biologicals were stored in a locked medication room, cabinet, or cart, not accessible to anyone not authorized to administer medications.	S3215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3215	Continued From page 20 Findings included: - By observation on 8/09/16 at 5:15pm, Operator/CNA (certified nurse aide) #I entered his/her office and retrieved a key to unlock the medication cupboard in the nursing office. By interview on 8/09/16 at 5:15pm, Operator/CNA #I confirmed as a CNA I am not able to pass medications... I have wondered about this for a long time... I keep the key in my office... all staff have access because all doors are master keyed the same as the Resident room doors... didn't know what to do when we didn't have a CMA (certified medication aide) or a licensed nurse on duty... when someone came in to pass medications had to have a way to get the keys... wasn't sure what to do about all that... Operator/CNA #I stated we do not have any TB (tuberculosis) testing solution right now, but historically have stored it in this small unlocked refrigerator in the nursing office... #I confirmed these facility practices did not ensure only those authorized to administer medications allowed access to the keys of the medication storage areas. The Licensed Nurses and CMA's failed to ensure that all medications and biologicals managed for Residents by facility were stored in a locked medication room, cabinet, or cart, not accessible to anyone not authorized to administer medications.	S3215		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 21 ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d) The facility census equalled 11 the sample included three Residents. The facility identified four employees hired since the last Resurvey. Based on interviews and reviews of records, the Operator failed to ensure disaster and emergency preparedness by conducting quarterly reviews of the facility's emergency management plan with employees and Residents. Findings included: - On 8/09/16 at 1:05pm, Operator/CNA (certified nurse aide) #I stated with employees " I do emergency preparedness depending on the season... we always talk about tornado and fire but then whatever is most pertinent to season... like power outage for winter storm... at Resident meetings I use our list of all topics... the list touches on each type of disaster. "	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3280	Continued From page 22 Operator/CNA #I stated the dates for reviews are as follow: Employees: 02/28/14 - reviewed whole emergency plan 11/15/15 - reviewed whole emergency plan 8/11/16 - have scheduled an emergency plan review Residents: 2014 - review completed 02/24/14, 4/25/14, 7/23/14, and 12/31/14 2015 - review completed 01/28/15, 4/29/15, and 7/31/15 2016 - review completed 01/27/16, and 3/10/16 On 8/09/16 at 1:18pm Operator/CNA #I confirmed we have not been doing the emergency plan reviews quarterly... I thought these were to be done annually... I was not aware the whole plan was to be done quarterly. The Operator failed to ensure reviews of the facility's emergency management plan completed quarterly with both employees and Residents.	S3280		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 23 the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(b)(5-6)(c) The facility census equalled 11 the sample included three Residents. The facility identified four employees hired since the last Resurvey with four reviewed. Based on interviews and reviews of records, for three of four employees reviewed (#A, #C, and #D), the Operator failed to ensure the facility's compliance with the Departments' tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of employee records on 8/09/16 with Operator/CNA (certified nurse aide) #I revealed the following: #A - CNA - hired 6/01/16 - one TB test administered 10/14/15 (more than six months prior to hire date) and one TB test administered 6/27/16 (more than seven days after hire). An additional TB test administered 7/11/16. All three tests documented as "neg" instead of "millimeters of induration" as required. TB questionnaire completed 6/27/16 also not completed within seven days of hire as required. #C - CNA - hired 7/18/16 - one TB test administered 8/05/16 (more than seven days after	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N094001	A. BUILDING: _____ B. WING _____	08/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3310	Continued From page 24 hire) #D - CNA - hired 7/18/16 - record contained an 8/14/15 "T Spot" test performed at the hospital. The employee file lacked a TB questionnaire. By interview on 8/09/16 at 3:00pm, Operator/CNA (certified nurse aide) #I stated for CNA #D, the hospital infection control department performed the "T Spot" testing due to employee showing positive results from a skin test. By interview on 8/09/16 at 3:23pm, Hospital Infection Control Staff #K stated CNA #D shows positive with a skin test so we do a T Spot test which showed negative... #K confirmed CNA #D due for an annual testing because the last TB testing completed 8/14/15. The Operator failed to ensure the facility's compliance with the Department's TB guidelines for adult care homes for employees #A, #C, and #D.	S3310		